Assembly Bill No. 984

CHAPTER 979

An act to amend Section 1345 of, and to add Sections 1363.2, 1371.5, and 1797.114 to, the Health and Safety Code, and to add Section 10126.6 to the Insurance Code, relating to emergency ''911'' telephone systems.

[Approved by Governor September 29, 1998. Filed with Secretary of State September 30, 1998.]

LEGISLATIVE COUNSEL'S DIGEST

AB 984, Davis. ''911'' emergency response system: health care coverage.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for licensure and regulation of health care service plans by the Commissioner of Corporations, and requires the commissioner to require each plan to use disclosure materials that provide, among other things, a description of any limitations on the patients choice of primary care or specialty care provider. Willful violation of those provisions is a crime. Existing law also provides for the regulation of policies of disability insurance by the Insurance Commissioner.

This bill would require, on or before July 1, 1999, the disclosure material to contain a statement that enrollees are encouraged to use appropriately the ''911'' emergency response system, as prescribed.

(2) Existing law requires that health care service plans and disability insurance policies provide coverage for certain services and treatments. Existing law requires a health care service plan, except a specialized health care service plan, to provide all basic health care services, defined to include, among other services, emergency health care services, including ambulance services and out-of-area coverage. The commissioner is authorized by rule to define the minimum scope of each basic health care service.

This bill would revise the definition of ''basic health services'' to provide that it includes ambulance and ambulance transport services provided through the ''911'' emergency response system.

(3) Existing law requires a health care service plan, or its contracting medical providers, to provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care, as defined, and is stabilized, but the treating provider believes that the enrollee may not be transferred or discharged safely.

This bill would prohibit a health care service plan that provides basic health care services from requiring prior authorization or refusing to pay for any ambulance and ambulance transport services provided to an enrollee as a result of a ''911'' emergency response system request for assistance if the request was made for an emergency medical condition and ambulance transport services were required or if the enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

This bill would require every disability insurance policy issued, amended, renewed, or delivered in this state, after January 1, 1999, that provides hospital, medical, or surgical coverage under specified health benefit plans that includes coverage for emergency health care services, to include coverage for medical transportation services, defined as ambulance services provided through the ''911'' emergency response system.

(4) Existing law requires the authority, pursuant to the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, to develop planning and implementation guidelines for emergency medical services systems that address, among other components, transportation. Existing law requires the authority to establish regulations and make determinations that would permit a local EMS agency to implement a local plan. Existing law prohibits the regulations, standards, and guidelines adopted by the authority and by local EMS agencies to prohibit a hospital that contracts with group practice prepayment health care service plans from providing necessary medical services for the members of the plan.

This bill would require that the rules and regulations of the authority include a requirement that a local EMS agency local plan require that in providing emergency medical transportation services to a patient that has a primary care facility designated by his or her health care service plan that the patient shall be transported to the closest appropriate medical facility, if the emergency health care needs of the patient dictate this course of action. By increasing the duties of the local EMS agency, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state,

reimbursement for those costs shall be made pursuant to these statutory provisions.

The people of the State of California do enact as follows:

SECTION 1. Section 1345 of the Health and Safety Code is amended to read:

1345. As used in this chapter:

(a) ''Advertisement'' means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) ''Basic health care services'' means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. ''Basic health care services'' includes ambulance and ambulance transport services provided through the ''911'' emergency response system.

(c) ''Enrollee'' means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) ''Evidence of coverage'' means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) ''Group contract'' means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(f) ''Health care service plan'' means any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(g) ''License'' means, and ''licensed'' refers to, a license as a plan pursuant to Section 1353.

(h) ''Out-of-area coverage,'' for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan's service area.

(i) ‘‘Provider’’ means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) ‘‘Person’’ means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) ‘‘Service area’’ means a geographical area designated by the plan within which a plan shall provide health care services.

(*l*) ‘‘Solicitation’’ means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(m) ‘‘Solicitor’’ means any person who engages in the acts defined in subdivision (k) of this section.

(n) ‘‘Solicitor firm’’ means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (k) of this section.

(o) ‘‘Specialized health care service plan contract’’ means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(p) ‘‘Subscriber’’ means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(q) Unless the context indicates otherwise, ‘‘plan’’ refers to health care service plans and specialized health care service plans.

(r) ‘‘Plan contract’’ means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

(s) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters which they purport to present, subject to any specific requirement imposed by this chapter or by the commissioner.

(t) This section shall become operative April 1, 1993.

SEC. 2. Section 1363.2 is added to the Health and Safety Code, to read:

1363.2. On or before July 1, 1999, the disclosure form required pursuant to Section 1363 shall also contain a statement that enrollees are encouraged to use appropriately the ''911'' emergency response system, in areas where the system is established and operating, when they have an emergency medical condition that requires an emergency response.

SEC. 3. Section 1371.5 is added to the Health and Safety Code, to read:

1371.5. (a) No health care service plan that provides basic health care services shall require prior authorization or refuse to pay for any ambulance or ambulance transport services, referred to in paragraph (6) of subdivision (b) of Section 1345, provided to an enrollee as a result of a ''911'' emergency response system request for assistance if either of the following conditions apply:

(1) The request was made for an emergency medical condition and ambulance transport services were required.

(2) An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

(b) As used in this section, ''emergency medical condition'' has the same meaning as in Section 1317.1.

(c) The determination as to whether an enrollee reasonably believed that the medical condition was an emergency medical condition that required an emergency response shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.

(d) A health care service plan shall not be required to pay for any ambulance or ambulance transport services if the health care service plan determines that the ambulance or ambulance transport services were never performed, an emergency condition did not exist, or upon findings of fraud, incorrect billings, the provision of services that were not covered under the member's current benefit plan, or membership that was invalid at the time services were delivered for the pending emergency claim.

SEC. 4. Section 1797.114 is added to the Health and Safety Code, to read:

1797.114. The rules and regulations of the authority established pursuant to Section 1797.107 shall include a requirement that a local EMS agency local plan developed pursuant to this division shall require that in providing emergency medical transportation services to any patient, the patient shall be transported to the closest appropriate medical facility, if the emergency health care needs of the patient dictate this course of action. Emergency health care need shall be determined by the prehospital emergency medical care personnel under the direction of a base hospital physician and

surgeon or in conformance with the regulations of the authority adopted pursuant to Section 1797.107.

SEC. 5. Section 10126.6 is added to the Insurance Code, to read:

10126.6. (a) Every policy of disability insurance that provides hospital, medical, or surgical coverage under a health benefit plan, defined in subdivision (a) of Section 10198.6, that provides coverage for emergency health care services, that is issued, amended, delivered, or renewed in this state on or after January 1, 1999, shall include coverage for emergency medical transportation services, as defined in subdivision (b). This coverage shall be provided without regard to whether the emergency provider has a contractual arrangement with the insurer or whether there was prior authorization, subject to the terms and conditions of the policy.

(b) For purposes of this section, ''emergency medical transportation services'' means ambulance services provided through the ''911'' emergency response system.

SEC. 6. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

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